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March 5, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Independence Avenue, NW
Washington, DC 20210

Ms. Jane Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA– Association Health Plans

Dear Secretary Acosta and Deputy Assistant Secretary Wilson:

On behalf of the American Heart Association (AHA) and the American Stroke Association (ASA), we appreciate this opportunity to submit comments on the Department of Labor's (DOL) proposed rule on Association Health Plans (AHPs).

As the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke, we would like to express our significant concerns with the AHP proposed rule. Our nonprofit and nonpartisan organization represents over 100 million patients with cardiovascular disease (CVD) and includes over 30 million volunteers and supporters committed to our goal of improving the cardiovascular health of all Americans. AHA has worked diligently for many years to support and advance strong public health policies in addition to providing critical tools and information to providers, patients, and families to prevent and treat these deadly diseases.

Indeed, the connection between health insurance and health outcomes is clear and thoroughly documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality

rates[1] and poorer blood pressure control than their insured counterparts.[2] Further, uninsured stroke patients suffer from greater neurological impairment, longer hospital stays[3], and higher risk of death than similar patients covered by health insurance.[4] Beyond the enormous physical toll, cardiovascular diseases is also costly and burdensome to patients, their families, and our systems of care.

We have long advocated for all Americans have access to affordable, quality health insurance coverage and care.[5] Throughout implementation of the Affordable Care Act (ACA), we remained steadfastly focused on access to affordable and adequate health insurance coverage. Since then, the AHA has worked to ensure that any health care proposal issued by Congress or the Administration to adjust the law was measured against a set of patient-focused principles.[6] They include:

- **Health Insurance Must be Affordable –** Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

- **Health Insurance Must be Accessible –** All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing, and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, per capita caps, or block granting.

- **Health Insurance Must be Adequate and Understandable –** All plans should be required to cover a full range of needed health benefits with a comprehensive and

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[1] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf
Accessed June 19, 2017.

[2] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.

[3] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.

[4] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare cove0rage. JAMA. 2007; 298:2886 –2894.

[5] American Heart Association, "Principles on Health Reform." Available at https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_306161.pdf.

[6] Consensus Healthcare Reform Principles. Accessed November 22, 2017 at: http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf

stable network of providers and plan features. Guaranteed access to preventive services -- without cost-sharing -- should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing a plan.

We are deeply concerned about the impact the Departments' proposed rule on Association Health Plans will have on the individuals and families we represent. While AHPs *can* offer more affordable coverage, they frequently lack important standards that shield patients from unnecessary risk including financial protections and coverage for essential health benefits.

It is a sad fact that AHPs have a long history of fraud and insolvency targeting small employers and individuals. Many plans collected premiums for health insurance coverage that did not exist. Some plans did not pay medical claims, leaving businesses, individuals, and providers exposed with millions of dollars in unpaid bills. For consumers and patients, the results were disastrous. We are extremely concerned that the proposed regulation will once again leave consumers with insufficient coverage, unpaid medical bills, and lifelong health implications – just as many AHPs did before the enactment of the ACA.

In the proposed rule, DOL recommends eliminating and/or altering several standards and regulatory structures that have served to protect patients and consumers, including those related to benefit structure, cost, and oversight. Using the principles of accessibility, affordability, and adequacy as our benchmark, we wish to express our deep concern about these policies and strongly encourage DOL to withdraw the Association Health Plan proposed rule.

Consumer Financial Protections & Fraud

For the 30 years prior to the Affordable Care Act, Association Health Plans were frequently used as a vehicle for selling fraudulent insurance coverage. Scams initially flourished after Congress exempted AHP arrangements from state oversight in 1974 through the Employee Retirement Income Security Act (ERISA).[7] AHPs could often set up headquarters in one state with limited regulatory oversight and market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards.[8]

In 1982, Congress responded to widespread fraud by amending ERISA to clarify states' authority to regulate association health plans and multiple employer welfare arrangements (MEWAs).[9] Because of this broad authority, many states limited the potential risks, including fraud, insolvency, and market segmentation, associated with

[7] Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from https://hpi.georgetown.edu/ahp.html

[8] Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority

[9] Association Health Plans are a type of multiple employer welfare arrangements (MEWAs).

the expanded AHP market.[10] Even with increased oversight, fraudulent insurance sold through associations remained a problem with enormous financial ramifications. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over $252 million in medical bills.[11] Four of the largest operations left 85,000 people with over $100 million in unpaid medical bills.[12] For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.[13]

AHPs also have a long history of financial instability and insolvency when medical claims exceed the association's ability to pay. There are no federal financial standards to guarantee that AHPs will remain financially stable, even though the proposed regulation could allow AHPs to cover millions more individuals and small employers. The Department has itself acknowledged that it does not have the capacity to act as a resource to consumers facing financial or legal issues as a result of these plans. It is unclear to the AHA how the government could offer reasonable assurances to consumers that they would not be harmed should these plans be allowed to proliferate.

We are extremely concerned that should the proposed regulation be enacted as written, it will once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, lifelong health implications, and no resources to challenge or seek remediation for these issues – just as AHPs did before the ACA provided appropriate oversight and protection. We are fundamentally concerned with AHPs overall ability to provide sound financial protection to patients and deliver on their responsibilities to make high quality care available to patients when needed. As such, the American Heart Association asks the administration to withdraw the rule.

Essential Health Benefits & Network Adequacy

The AHA's principles dictate that health care coverage must be adequate, covering the services and treatments patients need, including those with unique and complex medical needs. It is paramount that protections for these patients be preserved, including the essential health benefits (EHB) packages, the ban on annual and lifetime caps, and restrictions on premium rating. We are deeply concerned that the AHPs facilitated by this proposed rule would offer inadequate, even discriminatory, coverage to the communities we represent.

One of the most troubling aspects of Association Health Plans is that they do not have to comply with EHB coverage requirements that are the core of the ACA. This proposed rule would accomplish this by regulating AHPs as if they are *Employee Retirement Income Security Act* (ERISA)-governed, large-group health plans, sometimes known as single multi-employer plans that are exempt from many of the ACA's coverage requirements.

This is deeply concerning because patients with CVD rely on these coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, CVD patients would routinely be denied coverage for medically necessary care. Individuals would discover they were not

[10] ibid
[11] ibid
[12] ibid
[13] ibid

covered for emergency room services, adequate rehabilitation and habilitative benefits and patients with chronic illnesses would be denied coverage for life-improving, sometimes even life-saving, medications after the fact. According to the Kaiser Family Foundation, approximately 27 percent of American adults have a condition that would result in being denied health coverage.[14] Many of our patients who would once again face these same coverage denials within AHPs under this proposed rule, resulting in entirely inadequate coverage. This is unacceptable to the American Heart Association and its volunteers.

AHPs would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant QHPs must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, rehabilitation and habilitation, preventive, and emergency services, AHPs are not required to comply with these life-saving standards.

This is particularly concerning for the AHA as many of our patients need access to emergency services, outpatient care, rehabilitation, and specialty physicians. These important and medically necessary physicians and health services can also be some of the most expensive. Without regulation and oversight of network adequacy within AHPs, the physicians and services CVD patients rely on could be excluded from AHP provider networks altogether. For example, AHPs may choose to exclude all children's hospitals, cardiologists, or specialty clinics from their provider networks. In addition, AHPs would not be prohibited from including facilities too far away from beneficiaries to be truly accessible.

Anti-Discrimination

We are pleased that the proposed rule applies the HIPAA nondiscrimination provisions in § 2590.702(a) and § 2590.702(b) to AHPs. The nondiscrimination provisions continue to prevent AHPs from discriminating based on health status related factors against employer members or employers' employees, or dependents. As proposed, this would prevent AHPs from using health factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability to determine eligibility for benefits or in setting premiums. We strongly encourage the Department to retain this requirement in any final rule as it is essential to help protect both employers and their employees from discrimination based on health status. We support this provision applying to all AHPs, regardless of when they were established. AHPs currently in operation should be required to fully comply with nondiscrimination requirements, without exception, and without delay.

However, while this is an important provision of the proposed regulation, it does not go far enough because an AHP could still engage in other discriminatory practices against people with medical needs. For example, the proposal exempts AHPs from ACA consumer protections designed to protect people with preexisting conditions. An AHP would be exempt from EHB provisions, rate reforms, guaranteed issue, and single-risk pool requirements. Consequently, an AHP could simply avoid covering people and businesses with medical needs. Exploiting benefit design, an AHP could attract healthier groups by not providing coverage to higher-needs populations, such as those with cardiovascular disease who may require rehabilitative and habilitative services,

[14]https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/

emergency care, and prescription drugs. As a result, people who need such coverage would not enroll in AHP coverage. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. With CVD as the number one killer of women and half of the population with CVD being over the age of 60,[15] these rating practices are unacceptable. Rating practices could result in healthier groups being covered through an AHP and leaving vulnerable populations, such as those with cardiovascular disease and its risk factors, left with fewer, more expensive, and less comprehensive options.

It is well-known that the zip code in which an individual lives is indicative of that person's health status.[16] The proposed rule would allow AHPs to take advantage of these known disparities by avoiding certain geographic areas and thereby circumvent covering sicker populations, such as those with high incidence of heart disease and stroke. An AHP could also limit membership to a specific industry that has lower claims than another industry. By exempting AHPs from EHB, rate reforms, and guaranteed issue requirements, all of these discriminatory practices would be allowed.

In order to truly prevent discrimination in meaningful ways, the Department should strengthen the protections in this provision by preventing groups or associations from varying premium rates to different employer members based on gender, age, zip code or other geographic identifier, industry, or other factors that may be used to vary rates based on expected health care use. The final rule should also apply EHB, guaranteed issue and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs, where they exist, do not result in a segmented market.

Failure to extend these protections, in addition to protections against discrimination based on health status, to AHPs, will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices. In addition, a failure to extend these protections will place the regulated health insurance markets in serious jeopardy, as AHPs would be free to cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control.

Market Segmentation

We are also concerned about the impact of the proliferation of AHPs on the overall individual market. Individuals with serious and chronic conditions will be more likely to enroll in coverage offered in the exchange. Conversely, younger and healthier individuals, may be more likely to shop for coverage on the basis of premiums and thus, be more drawn to AHPs, despite the fact that these products will likely have less comprehensive coverage. As the National Association of Insurance Commissioners (NAIC) correctly notes, "while the rates may drop for those businesses that belong to

[15] Benjamin EJA, et al. Heart Disease and Stroke Statistics - 2018 Update, A Report from the American Heart Association. *Circulation*. 2018;137:XX–XX. DOI: 10.1161/CIR.0000000000000558.

[16] Robert Wood Johnson Foundation Life Expectancy maps using data from Life expectancy data -- Institute for Health Metrics and Evaluation, 2013.

associations, which offer health coverage, premiums will increase for the remaining pool."[17]

Over time, as younger and healthier individuals leave the marketplace, premiums will likely increase and fewer issuers may participate in a state's marketplace. This could lead to market segmentation that "could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."[18] Expanding access to substandard insurance products to the detriment of the comprehensive plans sold in the individual insurance market, is unacceptable by any standard that values the health of America's patients.

State Preemption & Oversight

The proposed rule raises questions about preemption of state law and future regulatory authority. While the Department states that the proposed rules do not alter existing ERISA statutory provisions governing multiple employer welfare arrangements, we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate them. The proposed rule's new framework allowing AHPs to be treated as large, single employer plans creates confusion about states' enforcement authority. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.[19]

States must maintain the ability to protect patients and manage their insurance markets. The American Heart Association opposes preemption of state law. We urge DOL to clarify that ERISA single employer AHPs, including those that cover more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Finally, we strongly oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in protecting patients by addressing AHP insolvencies and fraud and maintaining competitive markets. States have the history, resources, and local expertise to serve in this role; we strongly urge the Department to preserve that essential role.

Conclusion

The American Heart Association is committed to the continued implementation of federal health policy in a way that reflects our principles of patient access to affordable, understandable, and adequate healthcare. The weakening of oversight and consumer protection standards included in DOL's proposed rule could jeopardize access to meaningful coverage in a number of ways for vulnerable patients, including those with cardiovascular disease and stroke. We are concerned that this rule, combined with the

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[17] National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.

[18] American Academy of Actuaries, "Issue Brief: Association Health Plans", Feb. 2017, available at http://www.actuary.org/content/association-health-plans-0.

[19] Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority

series of actions taken by the administration, including decreased education and outreach funding, non-payment of CSRs, a shortened open enrollment period among others, and policies included in other proposed rules including the Notice of Benefit and Payment Parameters and Short Term Plans continue to erode consumers' ability to understand their coverage options, gain coverage, and improve their health.

We are not alone in these concerns. Many national patient and consumer advocacy organizations have voiced concern about both this proposed rule and AHP for many years. As we have previously discussed, there is significant evidence to support our conclusion that these products are of little value to patients with chronic or serious disease and that they pose a significant risk to the physical and financial health of enrollees. In an effort to help the Department understand the impact of this proposed rule on the CVD community, we respectfully request that the Department hold a public hearing on the proposed rule. We feel strongly that a public hearing would give the Department an additional opportunity to learn and understand how patients, families, caretakers and consumers would be impacted by the increased availability of AHPs.

We urge you to accept our recommendations about the impact of the proposed rule on the ability of CVD patients to seek adequate, understandable and affordable care, and therefore, withdraw the rule. If the Department ultimately decides to pursue this rule, we insist that comprehensive, easy to understand information about the risks of these plans and their coverage limitations be provided to all enrollees prior to purchase.

We look forward to working with the DOL and other stakeholders to promote quality, affordable care. If you have any questions regarding these comments, please contact Katie Berge, AHA Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

John Warner

Dr. John Warner, MD

Cc: The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services